SENATE BILL NO. 403

INTRODUCED BY Miller ORR

A BILL FOR AN ACT ENTITLED: "AN ACT RELATING TO HEALTH CARE ACCESS AND COST CONTROL; REQUIRING HEALTH CARE INSURERS TO OFFER A BASIC POLICY; PRESCRIBING MINIMUM REQUIREMENTS FOR DISABILITY INSURANCE; PROHIBITING THE COMMISSIONER OF INSURANCE FROM PROHIBITING CERTAIN PRACTICES FOR SETTING PREMIUMS; PROVIDING FOR STANDARDIZED DISABILITY INSURANCE CLAIMS FORMS, ELECTRONIC CLAIMS, AND MEDICAL DEBIT AND CREDIT CARDS; PROVIDING FOR MEDICAL SAVINGS ACCOUNTS; PROVIDING FOR A TAX EXEMPTION; AMENDING THE MONTANA COMPREHENSIVE HEALTH INSURANCE ASSOCIATION PLAN; REQUIRING HEALTH CARE INSURERS AND PROVIDERS TO FURNISH CERTAIN DATA UPON REQUEST BY ANY PERSON; PROVIDING DEFINITIONS; PROVIDING PENALTIES; REQUIRING A HEALTH INSURANCE RETURN; PROVIDING FOR PUBLIC SUPPORT OF INSURANCE FOR THE WORKING POOR; PROVIDING FOR A HEALTH CARE INFORMATION CLEARINGHOUSE; REPEALING THE SMALL EMPLOYER HEALTH INSURANCE AVAILABILITY ACT; AMENDING SECTIONS 15-30-111, 33-22-101, 33-22-1512, 33-22-1521, AND 39-71-704, MCA; REPEALING SECTIONS 33-22-110, 33-22-1801, 33-22-1802, 33-22-1803, 33-22-1804, 33-22-1808, 33-22-1809, 33-22-1810, 33-22-1811, 33-22-1812, 33-22-1813, 33-22-1814, 33-22-1818, 33-22-1819, 33-22-1820, 33-22-1821, AND 33-22-1822, MCA; AND PROVIDING EFFECTIVE DATES."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

Section 1. Section 33-22-101, MCA, is amended to read:

"33-22-101. Exceptions to scope. Parts 1 through 4 of this chapter, except [sections 2 through 6 and 27 through 33], 33-22-107, ~~33-22-110,~~ 33-22-111, 33-22-114, 33-22-125, 33-22-130 through 33-22-132, and 33-22-304, do not apply to or affect:

(1) any policy of liability or workers' compensation insurance with or without supplementary expense coverage;

(2) any group or blanket policy;

(3) life insurance, endowment, or annuity contracts or supplemental contracts that contain only

those provisions relating to disability insurance as:

(a) provide additional benefits in case of death or dismemberment or loss of sight by accident or accidental means; or

(b) operate to safeguard contracts against lapse or to give a special surrender value or special benefit or an annuity in the event that the insured or annuitant becomes totally and permanently disabled, as defined by the contract or supplemental contract;

(4) reinsurance."

NEW SECTION. **Section 2. Definitions.** As used in [sections 2 through 6], unless expressly provided otherwise, the following definitions apply:

(1) "Basic health benefits plan" or "basic plan" means the basic health benefits plan provided in [section 3].

(2) "Case characteristics" means demographic or other objective characteristics of an individual or group of individuals that are considered by the insurer in the determination of premium rates for the individual or group. However, claims experience and health status are considered case characteristics for purposes of [sections 2 through 6] only the first time that an individual or group of individuals purchases a health benefits plan following [the effective date of sections 2 through 6].

(3) "Dependent" means:

(a) a spouse or an unmarried child under 19 years of age;

(b) an unmarried child, under 23 years of age, who is a full-time student and who is financially dependent on the insured;

(c) a child of any age who is disabled and dependent upon the parent as provided in 33-22-506 and 33-30-1003; or

(d) any other individual defined to be a dependent in the health benefit plan covering the employee.

(4) (a) "Health benefits plan" means any hospital or medical policy or certificate providing for physical and mental health care issued by an insurance company, a fraternal benefit society, or a health service corporation or issued under a health maintenance organization subscriber contract.

(b) The term does not include:

(i) accident-only, credit, dental, vision, specified disease, medicare supplement, long-term care, or disability income insurance;

(ii) coverage issued as a supplement to liability insurance, workers' compensation insurance, or similar insurance; or

(iii) automobile medical payment insurance.

(5) "Health care insurer" or "insurer" means a health care insurer as defined in 33-22-125.

(6) "Health care provider" means a person who is licensed, certified, or otherwise authorized by the laws of this state to provide health care in the ordinary course of business or the practice of a profession.

(7) "Insurance producer" means an insurance producer as defined in 33-17-102.

(8) "Preexisting condition" means a preexisting condition as defined in 33-22-1501.

NEW SECTION. **Section 3. Basic health benefits plan.** (1) As a condition of transacting business in this state, each health care insurer shall offer a basic health benefits plan that provides the benefits specified by [section 4] and this section.

(2) Each insurer shall, pursuant to 33-1-501, file the basic health benefits plan offered by that insurer with the commissioner. The commissioner may at any time after providing notice and an opportunity for a hearing to the insurer disapprove the continued use of a basic health benefits plan because the plan does not meet the requirements of [section 4] or this section.

(3) A basic health benefits plan must be certified as meeting the minimum requirements for a basic health benefits plan if it otherwise meets the requirements of Title 33, chapters 15, 22 (except part 7), and 30, and other laws of this state and meets the following standards:

(a) The benefits for an insured must, subject to the other provisions of this section, be equal to at least 80% of the covered expenses required by this section in excess of an annual deductible that is not less than $1,000 per person. The coverage must include a limitation of $5,000 per person on the total annual out-of-pocket expenses for services covered under this section. Coverage may be subject to a maximum lifetime benefit, but the maximum may not be less than $1 million.

(b) Covered expenses must be the usual and customary charges, as contained in either the prevailing health care charges system data base, the medicode data base, or other prevailing health care charges system, to be chosen by the health care insurer for the following services and articles when prescribed by a physician or other licensed health care professional provided for in 33-22-111:

(i) hospital services;

(ii) professional services for the diagnosis or treatment of injuries, illness, or conditions, other than dental;

(iii) use of radium or other radioactive materials;

(iv) oxygen;

(v) anesthetics;

(vi) diagnostic x-rays and laboratory tests, except as specifically provided in subsection (3)(c)(i);

(vii) services of a physical therapist;

(viii) transportation provided by licensed ambulance service to the nearest facility qualified to treat the condition;

(ix) oral surgery for the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth or in connection with TMJ;

(x) rental or purchase of medical equipment, which must be reimbursed after the deductible has been met at the rate of 50%, up to a maximum of $1,000;

(xi) prosthetics, other than dental;

(xii) services of a licensed home health agency, up to a maximum of 180 visits per year;

(xiii) (A) drugs requiring a physician's prescription that are approved for use in human beings by the United States food and drug administration and that are listed in the United States Pharmacopoeia/National Formulary; or

(B) new and nonofficial remedies;

(xiv) medically necessary, nonexperimental organ transplants of the following major organs, limited to the following amounts, with an additional $10,000 to be paid for costs associated with the donor:

(A) kidney, $45,000;

(B) pancreas, $70,000;

(C) heart, $100,000;

(D) heart/lung, $140,000;

(E) liver, $150,000;

(F) bone marrow, $150,000;

(G) cornea, $8,000;

(xv) pregnancy, including complications of pregnancy;

(xvi) routine well baby care;

(xvii) sterilization;

(xviii) immunizations;

(xix) coverage for mental health, mental retardation, or substance abuse, or any combination, up to a maximum of 14 inpatient days per year and 26 outpatient hours per year, with a maximum dollar benefit of $10,000 per year;

(xx) outpatient rehabilitation therapy;

(xxi) foot care for diabetics;

(xxii) services of a convalescent home, as an alternative to hospital services, limited to a maximum of 60 days per year; and

(xxiii) travel, other than transportation provided by a licensed ambulance service, to the nearest facility qualified to treat the patient's medical condition when approved by the insurer's medical utilization review department.

(c) (i) Covered expenses for the services or articles specified in this section do not include:

(A) services of a nursing home, except as specifically provided in subsection (3)(b);

(B) home and office calls, except as specifically provided in subsection (3)(b);

(C) rental or purchase of durable medical equipment, except as specifically provided in subsection (3)(b);

(D) the first $20 of diagnostic x-ray and laboratory charges in each 14-day period;

(E) oral surgery, except as specifically provided in subsection (3)(b);

(F) that part of a charge for services or articles that exceeds the reasonable and customary charge in the locality where the service is provided;

(G) care that is primarily for custodial or domiciliary purposes that would not qualify as an eligible service under medicare; or

(H) treatment for TMJ.

(ii) Covered expenses for the services or articles specified in this section do not include charges for:

(A) care for any injury or disease arising out of an injury in the course of employment and subject to a workers' compensation or similar law and for which benefits are payable under another policy of disability insurance or medicare;

(B) treatment for cosmetic purposes other than surgery for the repair or treatment of an injury or

congenital bodily defect to restore normal bodily functions;

(C) travel other than transportation provided by a licensed ambulance service to the nearest facility qualified to treat the condition, unless approved by the insurer's utilization review department;

(D) confinement in a private room to the extent that the charge is in excess of the institution's charge for its most common semiprivate room, unless the private room is prescribed as medically necessary by a physician;

(E) services or articles the provision of which is not within the scope of authorized practice of the institution or individual rendering the services or articles;

(F) room and board for a nonemergency admission on Friday or Saturday;

(G) complications to a newborn, unless no other source of coverage is available;

(H) reversal of sterilization;

(I) acupuncture;

(J) abortion, unless the life of the mother would be endangered if the fetus were carried to term;

(K) weight modification or modification of the body to improve the mental or emotional well-being of an insured;

(L) artificial insemination or treatment for infertility; or

(M) breast augmentation or reduction.

(4) The basic health benefits plan is not subject to the following statutes: 33-22-111, 33-22-114, 33-22-125, 33-22-130 through 33-22-132, 33-22-301, 33-22-303 through 33-22-311, 33-22-503 through 33-22-510, 33-22-512, 33-22-703, 33-22-1001, 33-22-1002, 33-30-1001, 33-30-1004, and 33-30-1014.

NEW SECTION. **Section 4. Minimum requirements for all policies.** (1) Each health care insurer doing business in this state and each health benefits plan, including each group or individual disability policy, certificate of insurance, and membership contract that is delivered, issued for delivery, renewed, extended, or modified in this state must comply with the provisions of this section.

(2) A health care insurer may not, because of a preexisting condition, deny, exclude, or limit benefits for an individual for losses incurred following the effective date of the individual's coverage for an individual who was previously covered for at least 90 consecutive days under a health benefits plan offering at least the same benefits as the previous health benefits plan or the same benefits as the basic plan, whichever the individual prefers. An individual or group policy, certificate of insurance, or membership

contract may not be canceled for nonpayment of policy premiums or certificate or contract fees except upon 45 days' written notice from the health care insurer. During the 45-day period, the insurer shall renew the policy, certificate, or contract upon payment of the required policy premium or certificate or contract fee unless the insured has committed fraud in application for coverage or, with respect to group insurance, the group fails to comply with plan provisions regarding the minimum number or percentage of insureds.

(3) A person may not be denied coverage by a health care insurer because of the nature of the trade, occupation, industry, or business in which the person is employed, but the insurer may consider those factors as case characteristics in establishing rates for policies, certificates, or contracts. With respect to group and individual insurance policies, the premium charged for one group or individual must be the same as the premium charged for other groups or individuals with similar case characteristics and covered under similar policies.

(4) An employee covered by a health benefits plan, including a group or individual disability policy, certificate of insurance, or membership contract, in connection with the employee's employment for at least 1 year prior to termination of employment and application for coverage by another group or individual disability policy, certificate of insurance, or membership contract offered by another employer may, upon termination of employment, elect to either continue coverage under the employee's former benefit plan or to be covered by the health benefits plan of the new employer. The new employer is liable for the cost of the policy, certificate, or contract only to the extent of the amount normally paid to other employees of the employer for insurance coverage.

(5) Each health benefits plan must contain a provision that if an insured who is continuously covered for at least 90 days by a health benefits plan terminates employment or the employer otherwise terminates coverage, the insured must be offered, without evidence of insurability, an individual policy of hospital or medical services insurance on the insured and any dependents covered under the original health benefits plan. The premium on the individual plan must be at the insurer's then customary rate applicable to the insured for coverage under the individual plan, considering the case characteristics of the insured, but the premium may not be greater than 150% of the average premium charged by the five insurers writing the most individual insurance policies for disability insurance in the state, as determined by the amount of premiums received.

(6) An insurer may increase the policy premium for a group or individual policy or a certificate or

contract previously issued by that insurer because of a change in the attained age of the insured. Increases in policy premiums or certificate or contract fees for policies, certificates, or contracts previously issued by that insurer, based on factors other than attained age, must be distributed proportionately by premium amount to all the policy, certificate, and contract holders of that insurer in the state.

(7) Health care insurers and insurance producers shall provide at the point of application for each health benefits plan, including each group or individual disability policy, certificate of insurance, or membership contract that is delivered, issued for delivery, renewed, extended, or modified in this state following [the effective date of this section], a booklet or brochure setting forth in easily understood language the following items:

(a) the total cost of the policy, certificate, or contract;

(b) the history of increases or decreases for the previous 5 years in the premium amount or certificate or contract fee charged;

(c) the total potential deductibles, copayments, and other out-of-pocket expenses to the insured;

(d) the maximum lifetime benefits, stated in dollar amounts, allowed under the plan;

(e) the criteria that the health care insurer will use to increase policy premiums or certificate or contract fees and the mechanism or method by which any increases may be accomplished;

(f) if the policy, certificate, or contract uses the concept of "usual and customary" or "prevailing charge", an explanation of that concept, including the name and an explanation of any data base or other common method used to determine the rate, charge, or other matter referred to; and

(g) the percentage of any usual and customary charges that the health care insurer will pay to the insured under the plan.

(8) (a) An individual health benefits plan may not deny, exclude, or limit benefits for a covered individual for losses incurred more than 12 months following the effective date of the individual's coverage due to a preexisting condition. An individual health benefits plan may not define a preexisting condition more restrictively than:

(i) a condition that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment during the 24 months immediately preceding the effective date of coverage;

(ii) a condition for which medical advice, diagnosis, care, or treatment was recommended or received during the 24 months immediately preceding the effective date of coverage; or

(iii) a pregnancy existing on the effective date of coverage.

(b) (i) For the purposes of this subsection (8), "individual health benefits plan" means any hospital or medical expense policy or certificate, subscriber contract, or contract of insurance provided by a prepaid hospital or medical service plan or health maintenance organization subscriber contract and issued or delivered for issue to an individual or provided by any discretionary group trust policy providing hospital or medical expense coverage to individuals.

(ii) Individual health benefits plan does not include a self-insured group health plan; a self-insured multiemployer group health plan; a group conversion plan; an insured group health plan; accident-only, specified disease, short-term hospital or medical, hospital confinement indemnity, credit, dental, vision, medicare supplement, long-term care, or disability income insurance; coverage issued as a supplement to liability insurance; workers' compensation or similar insurance; or automobile medical payment insurance.

NEW SECTION. **Section 5. Commissioner not to prohibit premiums based on loss ratio guarantee.** The commissioner may not prohibit an insurer from determining the amount of a policy premium or certificate or contract fee based directly or indirectly upon a loss ratio guarantee.

NEW SECTION. **Section 6. Standardized claim form -- electronic claims -- medical debit and credit cards.** (1) The commissioner shall adopt by rule a uniform health insurance claim form using the health care financing administration form 1500 and uniform standards and procedures for the use of the forms and processing of claims, including the submission of claims by means of an electronic claims processing system. Submission of claims by means of an electronic claims processing system must be voluntary.

(2) A law may not be interpreted to prevent the use, by a health care insurer, an insured, or a health care provider, of a machine-readable, magnetic strip debit and credit card by which medical financial credits may be granted by an insurer to an insured for payment of health care providers. The card may be debited by health care providers.

NEW SECTION. **Section 7. Short title.** [Sections 7 through 13] may be cited as the "Montana Medical Savings Account Act of 1995".

NEW SECTION. **Section 8. Definitions.** As used in [sections 7 through 13], unless expressly provided otherwise, the following definitions apply:

(1) "Account administrator" means:

(a) a state or federally chartered bank, savings and loan association, credit union, or trust company authorized to do business in this state;

(b) a health care insurer;

(c) a broker-dealer, salesperson, investment adviser, or investment adviser representative as defined in 30-10-103 who is registered with the securities commissioner of this state pursuant to the Securities Act of Montana;

(d) a certified public accountant licensed pursuant to Title 37, chapter 50; or

(e) an employer.

(2) "Account holder" means an individual who establishes a medical savings account or for whose benefit the account is established.

(3) "Cafeteria plan" means a cafeteria plan established pursuant to 26 U.S.C. 125.

(4) "Department" means the department of revenue.

(5) "Dependent" means a dependent as defined in 15-30-113.

(6) "Eligible medical expense" means an expense paid by an employee or an account holder for medical care as defined by 26 U.S.C. 213(d) for the employee or account holder or a dependent of the employee or account holder that is not compensated for by insurance, by workers' compensation, or by any other method.

(7) "Employee" means an employee for whose benefit an account is established. The term includes a self-employed individual.

(8) "Health care plan" means a health benefits plan as defined in [section 2].

(9) "Knowingly" has the meaning defined in 45-2-101.

(10) "Medical savings account" or "account" means an account established in accordance with [section 9].

(11) "Person" means an individual, business association, partnership, corporation, sole proprietorship, firm, office, or governmental entity.

NEW SECTION. **Section 9. Medical savings accounts -- tax exemption -- conditions.** (1) An employee who is a resident of this state may establish a medical savings account for the employee or the employee's dependents. An employer may also, except as otherwise provided by contract or collective

bargaining agreement, establish a medical savings account for an employee of the employer. An individual who is a resident of this state may also establish a medical savings account for the individual or the individual's dependents. To qualify for the exemption provided in [section 10], the account must be established:

(a) with an account administrator within the United States; and

(b) with a contribution of principal from any source or combination of sources of an amount for a tax year that does not exceed the total cost for policy premiums, certificates or contract fees, deductible amounts, and copayments required for a health care plan with at least a $1,000 deductible.

(2) Before making contributions to a medical savings account, an employer shall inform the employee in writing of the state and federal tax status of contributions made to the account.

NEW SECTION. **Section 10. Tax exemption -- conditions.** (1) Except as provided in this section, the amount of principal provided for in subsection (2) contributed annually by an employee or an account holder to an account and all interest or other income on that principal may be excluded from the adjusted gross income of the employee or account holder and are exempt from taxation, in accordance with 15-30-111(2)(j), as long as the principal and interest are contained within the account.

(2) An employee or account holder may exclude an annual contribution equivalent to the total cost for policy premiums, certificate or contract fees, deductible amounts, and copayments required for a health care plan with at least a $1,000 deductible and may deduct interest or other earnings on that amount.

(3) A deduction pursuant to 15-30-121 is not allowed to an employee or account holder for an amount contributed to an account.

(4) Any part of the principal or income, or both, of an account and amounts withdrawn from the account for the payment of an eligible medical expense or for the long-term care of the employee, the account holder, or a dependent of the employee or account holder may be excluded under subsection (2). Except as provided in subsection (6), any part of the principal or income, or both, withdrawn from an account may not be excluded under subsection (2) and this subsection if the amount is withdrawn from the account and used for a purpose other than an eligible medical expense or the long-term care of the employee, the account holder, or a dependent of the employee or account holder.

(5) An amount exceeding twice the annual deductible of the health care plan for the employee or account holder who established the account may be withdrawn by the employee or account holder at any

time and, when withdrawn, must be taxed as ordinary income.

(6) An amount exceeding $10,000 in an account may be withdrawn by the employee or account holder without being taxable if the amount withdrawn is used for any of the following purposes:

(a) payment for postsecondary education for the employee or account holder or for someone in the immediate family of that individual;

(b) first-time purchase of a single-family home by the employee or account holder; or

(c) investment in a cafeteria plan or individual retirement account.

(7) An amount withdrawn from an account that is not used for eligible medical expenses, for the purposes provided in subsection (6), or for the long-term care of the employee, the account holder, or a dependent of the employee or account holder is taxable as ordinary income of the employee or account holder in the year that it is withdrawn.

(8) An employee or account holder may deposit into an account more than the amount allowed by subsection (2) if the exemption claimed by the employee or account holder is no more than the amount allowed by that subsection for each year in which that deposit will pay the health insurance expenses of the employee or account holder.

(9) Transfer of money in an account owned by the employee or account holder to the account of another employee or account holder within the immediate family of the first employee or account holder does not subject either employee or account holder to tax liability under this section. Amounts contained within the account of the receiving employee or account holder are subject to the requirements and limitations provided in this section.

(10) A change in the account administrator does not subject the employee or account holder to tax liability.

NEW SECTION. **Section 11. Duties of account administrator.** (1) An account administrator shall administer the medical savings account from which payment of claims is made and has a fiduciary duty to the individual for whose benefit the account is administered.

(2) The account administrator may use funds held in the account only for paying claims for eligible medical expenses of the employee or the employee's dependents or the account holder or the account holder's dependents, for the expenses of long-term care as provided in this section, and for paying costs of administering the account.

(3) The employee or account holder may submit documentation of eligible medical expenses paid by the employee or account holder in the tax year to the account administrator, and the account administrator shall reimburse the employee or account holder from the employee's or account holder's account for the eligible medical expense.

(4) The employee or account holder may submit documentation of the purchase of long-term care insurance or a long-term care annuity to the account administrator, and the account administrator shall reimburse the employee or account holder from the employee's or account holder's account for payments made for the purchase of the insurance or annuity. The account administrator may also provide for a system of automatic withdrawals from the account for the payment of long-term care insurance premiums or an annuity. When amounts are withdrawn in accordance with this subsection for long-term care of the employee, the account holder, or a dependent of the employee or account holder, those amounts withdrawn are not subject to taxation.

(5) If an employer makes contributions to an account on a periodic installment basis, the employer may advance to the employee, interest free, an amount necessary to cover medical expenses incurred that exceeds the amount in the employee's account at the time the expense is incurred if the employee agrees to repay the advance from future installments or when the employee ceases employment with the employer.

(6) An account administrator who receives a written request to transfer an account to another account administrator shall transfer the account within 30 days of receipt of the request. An employee who leaves the employment of an employer making contributions to an account on behalf of the employee may, within 60 days of leaving that employment, request in writing that the account administrator continue to maintain the account of the former employer. An account administrator who refuses to maintain the account as requested or who does not state in writing within 30 days of the expiration of the 60-day period that the administrator will continue to maintain the account shall close the account of the former employee and send any remaining funds in the account to the former employee.

(7) The account administrator shall by March 1 of each year certify to the department for the previous year the amount of principal and interest or other earnings in each account and shall also certify the amount of the policy premium, certificate or contract fees, deductible amounts, and copayments required by the health care plan for every employee or account holder paying those expenses from a medical savings account.

(8) Within 30 days of being furnished proof of the death of the employee or account holder, the

account administrator shall distribute the principal and accumulated interest in the account to the estate of the employee or account holder.

NEW SECTION. **Section 12. False claims prohibited -- penalty.** (1) A person may not knowingly prepare or cause to be prepared a false claim, receipt, statement, or billing to justify the withdrawal of money from an account.

(2) A person who violates subsection (1) by preparing or causing the preparation of a false claim, receipt, statement, or billing in an amount not exceeding $300 is guilty of theft and upon conviction shall be fined an amount not to exceed $500 or be imprisoned in the county jail for a term not to exceed 6 months, or both. A person convicted of a second offense shall be fined $500 or be imprisoned in the county jail for a term not to exceed 6 months, or both. A person convicted of a third or subsequent offense shall be fined $1,000 and be imprisoned in the county jail for a term of not less than 30 days or more than 6 months.

(3) A person who violates subsection (1) by preparing or causing the preparation of a false claim, receipt, statement, or billing in an amount of $300 or more is guilty of theft and upon conviction shall be fined an amount not to exceed $50,000 or be imprisoned in the state prison for a term not to exceed 10 years, or both.

(4) Amounts involved in thefts committed pursuant to a common scheme or the same transaction, whether from the same person or several persons, may be aggregated in determining the value of the amount withdrawn from an account in violation of this section.

NEW SECTION. **Section 13. Rulemaking.** The department shall adopt rules implementing [sections 7 through 13]. The rules must include rules governing the duties of account administrators. The rules must be adopted in consultation with the commissioner of insurance.

Section 14. Section 15-30-111, MCA, is amended to read:

"**15-30-111. Adjusted gross income.** (1) Adjusted gross income ~~shall be~~ is the taxpayer's federal income tax adjusted gross income as defined in section 62 of the Internal Revenue Code of 1954 or as that section may be labeled or amended and in addition ~~shall include~~ includes the following:

(a) interest received on obligations of another state or territory or county, municipality, district, or

other political subdivision thereof;

(b) refunds received of federal income tax, to the extent the deduction of ~~such~~ the tax resulted in a reduction of Montana income tax liability;

(c) that portion of a shareholder's income under subchapter S. of Chapter 1 of the Internal Revenue Code of 1954, that has been reduced by any federal taxes paid by the subchapter S. corporation on the income; and

(d) depreciation or amortization taken on a title plant as defined in 33-25-105(15).

(2) Notwithstanding the provisions of the federal Internal Revenue Code of 1954, as labeled or amended, adjusted gross income does not include the following which are exempt from taxation under this chapter:

(a) all interest income from obligations of the United States government, the state of Montana, county, municipality, district, or other political subdivision thereof;

(b) interest income earned by a taxpayer age 65 or older in a taxable year up to and including $800 for a taxpayer filing a separate return and $1,600 for each joint return;

(c) (i) except as provided in subsection (2)(c)(ii), the first $3,600 of all pension and annuity income received as defined in 15-30-101;

(ii) for pension and annuity income described under subsection (2)(c)(i), as follows:

(A) each taxpayer filing singly, head of household, or married filing separately shall reduce the total amount of the exclusion provided in (2)(c)(i) by $2 for every $1 of federal adjusted gross income in excess of $30,000 as shown on the taxpayer's return;

(B) in the case of married taxpayers filing jointly, if both taxpayers are receiving pension or annuity income or if only one taxpayer is receiving pension or annuity income, the exclusion claimed as provided in subsection (2)(c)(i) must be reduced by $2 for every $1 of federal adjusted gross income in excess of $30,000 as shown on their joint return;

(d) all Montana income tax refunds or tax refund credits;

(e) gain required to be recognized by a liquidating corporation under 15-31-113(1)(a)(ii);

(f) all tips covered by section 3402(k) of the Internal Revenue Code of 1954, as amended and applicable on January 1, 1983, received by persons for services rendered by them to patrons of premises licensed to provide food, beverage, or lodging;

(g) all benefits received under the workers' compensation laws;

(h) all health insurance premiums paid by an employer for an employee if attributed as income to the employee under federal law; ~~and~~

(i) all money received because of a settlement agreement or judgment in a lawsuit brought against a manufacturer or distributor of "agent orange" for damages resulting from exposure to "agent orange"; and

(j) principal and income in a medical savings account established in accordance with [section 9] or withdrawn from an account for eligible medical expenses as defined in [section 8] or for the long-term care of the taxpayer.

(3) A shareholder of a DISC that is exempt from the corporation license tax under 15-31-102(1)(l) shall include in ~~his~~ adjusted gross income the earnings and profits of the DISC in the same manner as provided by federal law (section 995, Internal Revenue Code) for all periods for which the DISC election is effective.

(4) A taxpayer who, in determining federal adjusted gross income, has reduced ~~his~~ business deductions by an amount for wages and salaries for which a federal tax credit was elected under section 44B of the Internal Revenue Code of 1954 or as that section may be labeled or amended is allowed to deduct the amount of the wages and salaries paid regardless of the credit taken. The deduction must be made in the year the wages and salaries were used to compute the credit. In the case of a partnership or small business corporation, the deduction must be made to determine the amount of income or loss of the partnership or small business corporation.

(5) Married taxpayers filing a joint federal return who ~~must~~ include part of their social security benefits or part of their tier 1 railroad retirement benefits in federal adjusted gross income may split the federal base used in calculation of federal taxable social security benefits or federal taxable tier 1 railroad retirement benefits when they file separate Montana income tax returns. The federal base must be split equally on the Montana return.

(6) A taxpayer receiving retirement disability benefits who has not attained age 65 by the end of the taxable year and who has retired as permanently and totally disabled may exclude from adjusted gross income up to $100 per week received as wages or payments in lieu of wages for a period during which the employee is absent from work due to the disability. If the adjusted gross income before this exclusion and before application of the two-earner married couple deduction exceeds $15,000, the excess reduces the exclusion by an equal amount. This limitation affects the amount of exclusion, but not the taxpayer's

eligibility for the exclusion. If eligible, married individuals shall apply the exclusion separately, but the limitation for income exceeding $15,000 is determined with respect to the spouses on their combined adjusted gross income. For the purpose of this subsection, permanently and totally disabled means unable to engage in any substantial gainful activity by reason of any medically determined physical or mental impairment lasting or expected to last at least 12 months. (Subsection (2)(f) terminates on occurrence of contingency--sec. 3, Ch. 634, L. 1983.)"

Section 15. Section 33-22-1512, MCA, is amended to read:

"**33-22-1512. Association plan premium.** The association shall establish the schedule of premiums to be charged eligible persons for membership in the association plan. The schedule of premiums may not be ~~less than 150% or~~ more than ~~400%~~ 150% of the average premium rates charged by the five insurers with the largest premium amount of individual plans of major medical insurance in force in this state. The premium rates of the ~~five~~ insurers used to establish the ~~premium rates for each type of coverage offered by the association~~ average premium rate must be determined by the commissioner from information provided annually by all insurers at the request of the commissioner. The association shall ~~utilize~~ use generally acceptable actuarial principles and structurally compatible rates."

Section 16. Section 33-22-1521, MCA, is amended to read:

"**33-22-1521. Association plan -- minimum benefits.** A plan of health coverage must be certified as an association plan if it otherwise meets the requirements of Title 33, chapters 15, 22 (excepting part 7), and 30, and other laws of this state, whether or not the policy is issued in this state, and meets or exceeds the following minimum standards:

(1) The minimum benefits for an insured must, subject to the other provisions of this section, be equal to at least 80% of the covered expenses required by this section in excess of an annual deductible that does not exceed $1,000 per person. The coverage must include a limitation of $5,000 per person on the total annual out-of-pocket expenses for services covered under this section. Coverage must be subject to a maximum lifetime benefit, but such maximums may not be less than ~~$100,000~~ $500,000.

(2) Covered expenses must be the usual and customary charges, as contained in the prevailing health care charges system data base or the medicode data base, for the following services and articles when prescribed by a physician or other licensed health care professional provided for in 33-22-111:

(a) hospital services;

(b) professional services for the diagnosis or treatment of injuries, illness, or conditions, other than dental;

(c) use of radium or other radioactive materials;

(d) oxygen;

(e) anesthetics;

(f) diagnostic x-rays and laboratory tests, except as specifically provided in subsection (3);

(g) services of a physical therapist;

(h) transportation provided by licensed ambulance service to the nearest facility qualified to treat the condition;

(i) oral surgery for the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth or in connection with TMJ;

(j) rental or purchase of medical equipment, which shall be reimbursed after the deductible has been met at the rate of 50%, up to a maximum of $1,000;

(k) prosthetics, other than dental; ~~and~~

(l) services of a licensed home health agency, up to a maximum of 180 visits per year;

(m) (i) drugs requiring a physician's prescription that are approved for use in human beings by the United States food and drug administration and that are listed in the United States Pharmacopoeia/National Formulary; or

(ii) new and nonofficial remedies;

(n) medically necessary, nonexperimental organ transplants of the following major organs, limited to the following amounts, with an additional $10,000 for costs associated with the donor:

(i) kidney, $45,000;

(ii) pancreas, $70,000;

(iii) heart, $100,000;

(iv) heart/lung, $140,000;

(v) liver, $150,000;

(vi) bone marrow, $150,000;

(vii) cornea, $8,000;

(o) pregnancy, including complications of pregnancy;

(p) routine well baby care;

(q) sterilization or reversal of sterilization;

(r) outpatient rehabilitation therapy;

(s) immunizations;

(t) coverage for mental health, mental retardation, or substance abuse, or any combination, up to a maximum of 14 inpatient days per year and 26 outpatient hours per year, with a maximum dollar benefit of $10,000 per year;

(u) foot care for diabetics;

(v) services in a convalescent home, as an alternative to hospital services, limited to a maximum of 60 days per year; and

(w) travel other than transportation provided by a licensed ambulance service to the nearest facility qualified to treat the condition when approved by the insurer's utilization review department.

(3) (a) Covered expenses for the services or articles specified in this section do not include:

(i) drugs requiring a physician's prescription, except as provided in subsection (2);

(ii) services of a nursing home, except as provided in subsection (2);

(iii) home and office calls, except as specifically provided in subsection (2);

(iv) rental or purchase of durable medical equipment, except as specifically provided in subsection (2);

(v) the first $20 of diagnostic x-ray and laboratory charges in each 14-day period;

(vi) oral surgery, except as specifically provided in subsection (2);

(vii) benefits for mental health, mental retardation, or substance abuse, except as specifically provided in subsection (2);

(viii) treatment of TMJ;

~~(vii)~~(ix) that part of a charge for services or articles ~~which~~ that exceeds the prevailing charge in the locality where the service is provided; or

~~(viii)~~(x) care that is primarily for custodial or domiciliary purposes ~~which~~ that would not qualify as an eligible ~~services~~ service under medicare.

(b) Covered expenses for the services or articles specified in this section do not include charges for:

(i) care or for any injury or disease either arising out of an injury in the course of employment and

subject to a workers' compensation or similar law~~,~~ and for which benefits are payable under another policy of disability insurance or medicare;

(ii) treatment for cosmetic purposes other than surgery for the repair or treatment of an injury or congenital bodily defect to restore normal bodily functions;

(iii) travel other than transportation provided by a licensed ambulance service to the nearest facility qualified to treat the condition;

(iv) confinement in a private room to the extent ~~it~~ that the charge is in excess of the institution's charge for its most common semiprivate room, unless the private room is prescribed as medically necessary by a physician;

(v) services or articles the provision of which is not within the scope of authorized practice of the institution or individual rendering the services or articles;

(vi) organ transplants, including bone marrow transplants, except as provided in subsection (2);

(vii) room and board for a nonemergency admission on Friday or Saturday;

~~(viii) pregnancy, except complications of pregnancy;~~

~~(ix) routine well-baby care;~~

~~(x)~~(viii) complications to a newborn, unless no other source of coverage is available;

~~(xi) sterilization or reversal of sterilization;~~

~~(xii)~~(ix) abortion, unless the life of the mother would be endangered if the fetus were carried to term;

~~(xiii)~~(x) weight modification or modification of the body to improve the mental or emotional well-being of an insured;

~~(xiv)~~(xi) artificial insemination or treatment for infertility; or

~~(xv)~~(xii) breast augmentation or reduction."

NEW SECTION. **Section 17. Definitions.** As used in [sections 17 through 19], unless expressly provided otherwise, the following definitions apply:

(1) "Health benefits plan" or "plan" means a health benefits plan as defined in [section 2].

(2) "Health care insurer" or "insurer" means a health care insurer as defined in 33-22-125.

(3) "Health care provider" or "provider" means a health care provider as defined in [section 2], except a hospital.

(4) "Health care service" or "service" means a service, procedure, item, or appliance provided by a health care provider.

(5) "Hospital" means a hospital as defined in 50-5-101.

NEW SECTION. **Section 18. Insurers and health care providers -- duty to provide payment and cost data -- penalties.** (1) Insurers, hospitals, and health care providers shall, upon request by any person, provide the health care data required by this section directly to the person making the request. A reasonable fee, not exceeding the actual cost of providing the data to the person requesting the data, may be charged by the insurer, hospital, or provider.

(2) A health care provider shall, within 30 days of a request by any person, furnish in writing the provider's current charge for each health care service sold by that provider. The charge must be listed by common procedural terminology code number, unless the provider uses another widely recognized standard coding system for its services, in which case the provider may use the other coding system. The charges must be furnished, upon request, in a standard electronic format rather than a written format if the provider maintains the charges in an electronic format.

(3) A hospital shall, within 30 days of a request by any person, furnish in writing the hospital's current charge for each health care service sold by that hospital. The charges must be furnished, upon request, in a standard electronic format rather than a written format if the hospital maintains the charges in an electronic format.

(4) A health care insurer shall, upon request by any person, provide any of the following information:

(a) a current and complete listing clearly identifying all of the health benefits plans sold in the state by that insurer and, for each of those plans, any of the following information:

(i) the current premium amount or certificate or contract fee charged for each health benefits plan;

(ii) the total potential deductibles, copayments, and other out-of-pocket expenses to the insured;

(iii) the maximum lifetime benefits, stated in dollar amounts, allowed under each plan;

(iv) the criteria that the health care insurer will use to increase policy premiums or certificate or contract fees and the mechanism or method by which any increases may be accomplished;

(v) if the policy, certificate, or contract uses the concept "usual and customary" or "prevailing charges" with regard to the payment for services of health care providers, an explanation of that concept,

including any data base or other common method used to determine the rate, charge, or fee referred to;

(vi) the percentage of any usual and customary charges by a health care provider that the health care insurer will pay to the insured under the plan;

(vii) the benefits available to the insured;

(viii) an explanation of rate "bands" or increments by which an insurer groups characteristics, such as age, that determine the amount of the policy premium or certificate or contract fee to be charged; and

(b) the history of increases and decreases in premiums or certificate or contract fees charged for each health benefits plan sold by the insurer over the previous 5 years.

NEW SECTION. **Section 19. Insurers to provide payment information -- penalties.** A health care insurer and an insurance producer, as defined in 33-7-525, for a health care insurer shall provide, upon request by any person, the health care cost data required by [section 18] to the person making the request. A health care insurer failing to provide the payment data required by [section 18] is subject to an administrative penalty of $1,000 for each failure, to be imposed by the commissioner pursuant to Title 33, chapter 1, part 7. An insurance producer who has been furnished the payment data referred to in [section 18] by the producer's insurer and who fails to provide the payment data required by [section 18] is subject to an administrative penalty of $500 for each failure, to be imposed by the commissioner pursuant to Title 33, chapter 1, part 7.

NEW SECTION. **Section 20. Health care providers to furnish payment information -- penalty.** (1) Physicians and other health care providers, as defined in [section 2], shall provide, upon request by any person, the health care cost data required by [section 18] to the person making the request.

(2) Failure to provide the health care cost data as required by this section is punishable as unprofessional conduct by the board of medical examiners or other licensing authority with licensing jurisdiction over the health care provider. If unprofessional conduct is not punishable by the authority with licensing jurisdiction over the health care provider, failure to provide the requested price information is punishable by a fine of not more than $500 per occurrence.

NEW SECTION. **Section 21. Hospitals to provide cost data -- penalty.** (1) Hospitals shall, upon request by any person, provide the health care cost data required by [section 18] to the person making the

request.

(2) A hospital that fails to provide the health care cost data as required by this section is subject to the civil penalties provided in 50-5-112 and to the administrative enforcement procedures of 50-5-114 for each failure.

NEW SECTION. **Section 22. Health insurance return required -- failure to file -- effect.** (1) A taxpayer required by 15-30-142 to file a return shall, on the date prescribed by law for the filing of the return, also file with the department on a form prescribed by that department a health insurance return containing the information required by this section and as may be further prescribed by the department.

(2) The completed health insurance return must disclose whether the taxpayer and any of the taxpayer's dependents are insured by a health benefits plan of a health care insurer equivalent to the basic health benefits plan, all as defined in [section 2]. If the taxpayer states that insurance coverage exists, then the taxpayer shall also provide the name of the insurer and the policy, contract, group, certificate, or other identifying number of the plan under which coverage is provided. The information required by this subsection must be made available at least annually by the department of revenue to the department of social and rehabilitation services in the form and at the time determined by the department of revenue.

(3) The health insurance return must inform the taxpayer in general terms of the financial and social risks normally associated with a lack of disability insurance coverage for the taxpayer and the taxpayer's dependents and of the qualification requirements for medical assistance pursuant to Title 53, chapter 6, part 1.

(4) A civil, criminal, or equitable penalty or remedy of any kind may not be applied by the department of revenue for the failure of a taxpayer to properly complete or file the health care return required by this section.

NEW SECTION. **Section 23. Definitions.** As used in [sections 23 through 26], unless expressly provided otherwise, the following definitions apply:

(1) "Basic plan" means the basic health benefits plan as defined in [section 2].

(2) "Commissioner" means the commissioner of insurance as provided in 2-15-1903.

(3) "Contract" means the contract required by [section 24].

(4) "Contractor" means the party to the contract, other than the department, required by [section

24].

(5) "Department" means the department of social and rehabilitation services created in 2-15-2201.

(6) "Health care provider" means a health care provider as defined in [section 2].

(7) "Health insurance expense" means an expense for the payment of individual or group health insurance policy, or certificate or contract fee, and copayments and deductibles.

(8) "Insurer" means a health care insurer as defined in 33-22-125.

(9) "Medical savings account" or "account" means an account established in accordance with [section 9].

(10) "Working poor" means a person who:

(a) has been a resident of Montana for at least 1 year prior to application for a health care credit pursuant to [section 24];

(b) does not qualify for medical benefits under the Montana medicaid program administered pursuant to Title 53, chapter 6;

(c) whose gross income is less than $100,000 per year; and

(d) whose health care expenses for any income bracket shown in the table in [section 25] are equal to the expenses shown in that table.

NEW SECTION. **Section 24. Department to contract for credits for working poor -- contract specifications.** (1) The department shall, by competitive sealed bid subject to Title 18, chapter 4, contract with a private office, firm, partnership, corporation, or other private business entity for payment of a health care credit to any member of the working poor for the payment of health insurance expenses.

(2) The contract must require that the contractor compute the credit according to subsection (3) and, upon application by the owner of the account, credit the amount computed to a medical savings account established for receipt of the credit. A credit may not be made by the contractor except to a medical savings account established in accordance with [section 9].

(3) The amount of the credit awarded by the contractor may be no more than is necessary for the recipient to purchase the basic plan with an annual deductible of $1,000, minus the recommended liability provided in the rules of the commissioner required by [section 25], plus any deductible required by the basic plan.

(4) The contract must require the contractor to establish a method of payment of the basic plan

premium from the medical savings account to the insurer providing the basic plan. The contract must also require that payment from the account may be made by electronic credit, voucher, or check, with appropriate means to ensure that the credit, voucher, or check is used only for the purchase of a basic policy.

(5) The contract must require that if the recipient of the credit expends less than the deductible amount required by the basic plan in any year, one-half of the credit deposited into the account, along with accrued interest, will be transferred to the state general fund and one-half of the credit deposited into the account, along with accrued interest, will be paid to the recipient. A recipient may choose to leave in the account an amount transferred in accordance with this subsection.

NEW SECTION. **Section 25. Table of insurance liability -- rulemaking by commissioner.** (1) Individuals and families with the following adjusted gross incomes are responsible for the payment of the following minimum and maximum percentages of their adjusted gross incomes for health insurance expenses, including premiums, deductibles, and copayments:

Adjusted Gross Income (AGI)	Minimum Limit (in % of AGI)		Maximum Limit (in % of AGI)	
	Individual/Family		Individual/Family	
$0 - $4,000	0.5%	0.5%	5%	5%
$5,000 - $9,999	1%	1%	7%	5%
$10,000 - $14,999	1.5%	1.5%	8%	8%
$15,000 or more	2.5%	2.5%	9%	10%

(2) The commissioner shall adopt rules, consistent with the table in subsection (1), specifying the amount of insurance liability for individuals and families. The contractor shall, in accordance with [section 24], credit to an individual or family the amount required by that subsection, after subtraction of the insurance liability provided in the rules of the commissioner, for the purchase of the basic plan.

NEW SECTION. **Section 26. Information required for clearinghouse -- insurer to refuse payment.** (1) An insurer providing coverage purchased by a credit paid pursuant to [section 24] may not furnish a benefit or pay a claim to a physician or other health care provider who has not furnished the information

required to be submitted to the information clearinghouse established pursuant to [section 28].

(2) The information clearinghouse established pursuant to [section 28] shall provide to insurers on a quarterly basis a listing of those health care providers furnishing the information required to be provided by the clearinghouse.

NEW SECTION. **Section 27. Definitions.** As used in [sections 27 through 33], unless expressly provided otherwise, the following definitions apply:

(1) "Health benefits plan" or "plan" means a health benefits plan as defined in [section 2].

(2) "Health care coverage" or "coverage" means payment by an insurer for, or direct provision of, health care services.

(3) "Health care insurer" or "insurer" means a health care insurer as defined in 33-22-125.

(4) "Health care provider" or "provider" means a health care provider as defined in [section 2].

(5) "Health care service" or "service" means a service, item, or appliance provided by a health care provider.

(6) "Information clearinghouse" or "clearinghouse" means a person who enters into a contract with the commissioner pursuant to [section 28] to provide health care information.

NEW SECTION. **Section 28. Commissioner to contract for information clearinghouse services.** The commissioner shall, by competitive sealed bid subject to Title 18, chapter 4, contract with a private office, firm, partnership, corporation, or other private business entity for the health care information clearinghouse services provided in [sections 27 through 33].

NEW SECTION. **Section 29. Information to be submitted to clearinghouse -- penalty -- formats.** (1) Health care providers shall submit to the clearinghouse, at a time and in a format prescribed by the commissioner, the health care information required by [section 31] to be provided by the clearinghouse upon request by any person.

(2) A health care insurer and an insurer as defined in 39-71-116 may not make a payment for a benefit required by 39-71-704 or [section 24] to a health care provider who fails to submit the required information to the clearinghouse or who fails to submit the information at the time or in the format required by this section and by the rules of the commissioner.

(3) The commissioner shall prescribe the time and format in which information must be submitted to the clearinghouse. The information submitted must comply with 33-15-321 through 33-15-329, except as otherwise provided by the commissioner. The contract between the commissioner and the information clearinghouse required by this section must require that information required to be provided by this section and [section 31] must comply with 33-15-321 through 33-15-329 and the rules of the commissioner. The contract must also require that the information provided by the clearinghouse must upon request by any person be provided in writing or in an electronic format prescribed by the commissioner.

NEW SECTION. **Section 30. Insurers and health care providers -- duty to provide payment and cost data directly.** (1) Insurers and health care providers shall provide, upon request by any person, the health care cost data required by this section directly to the person making the request. The data provided pursuant to this section need not be provided in compliance with the format, style, or language requirements prescribed by the commissioner pursuant to [section 29]. An insurer or health care provider may charge a reasonable fee to the person requesting the data in order to pay for costs of copying and mailing.

(2) A health care provider shall, upon request by any person, provide the information required by [section 31(1)(a)] to be provided by the health care clearinghouse.

(3) A health care insurer shall, upon request by any person, provide the following information:

(a) a current and complete listing clearly identifying all of the health benefits plans sold by that insurer in the state;

(b) the premium amount or certificate or contract fee charged;

(c) the history of increases or decreases for the previous file years of the premium amount or certificate or contract fee charged;

(d) the total potential deductibles, copayments, and other out-of-pocket expenses to the insured;

(e) the maximum lifetime benefits, stated in dollar amounts, allowed under the plan;

(f) the criteria that the health care insurer will use to increase premiums or contract or certificate fees, and the mechanism or method by which any increases may be accomplished;

(g) if the policy, contract, or certificate uses the term "usual and customary", an explanation of that term, including any data base or other common method used to determine the rate, charge, or other matter referred to; and

(h) the percentage of any usual and customary charges that the health care insurer will pay to the insured under the plan.

NEW SECTION. **Section 31. Contract specification -- current prices and price history.** (1) The clearinghouse shall provide the current price and the price for each of the 5 years prior to a request for information for the following:

(a) health care coverage offered or issued within the state for each policy or coverage type, including:

(i) the policy, membership, or other coverage premium or fee;

(ii) the amount of deductibles and copayments;

(iii) any limitation on total policy or coverage amounts provided;

(iv) the amount that will be and has been paid to a health care provider, except a hospital, for a particular health care service or for all health care services, to be listed by the common procedural terminology code number; and

(v) the amount that will be and has been paid to a hospital for outpatient and inpatient services for a particular health care service or for all health care services;

(b) health care provider charges, except for hospitals, for a particular health care service or for each health care service, to be listed by common procedural terminology code number; and

(c) hospital charges for a particular health care service, or for each health care service, whether outpatient or inpatient, to be listed by the international classification of diseases code number and to include the average total charge by each hospital for distinct elective procedures.

(2) If global pricing for a particular health care service or procedure is available at a hospital, that pricing for the particular service or procedure or for all services and procedures must be provided upon request.

NEW SECTION. **Section 32. Contract specification -- conversion factor.** The contract required by [section 28] must require the clearinghouse to:

(1) determine a single number conversion factor by which the price of health care coverage among and between health care insurers and the price of each health care service may be easily compared;

(2) make available, upon request by any person, the conversion factors for all health care insurers,

providers, and hospitals, as well as the average conversion factor for each of those groups, to be listed by medical specialty, by health care service or individual elective procedure, by inpatient and outpatient service, and by any other means by which an easy and logical comparison of costs may be made between and among health care insurers, providers, and hospitals; and

(3) make available, upon request by any person, the conversion factor listed by individual elective procedure for which a total price on that elective procedure is available from a health care provider.

NEW SECTION. **Section 33. Contract specification -- pro forma rating.** The contract required by [section 28] must require the clearinghouse to calculate a pro forma rating by which all health insurance coverage will be rated as to price and coverage by a single letter designation so that a comparison of price and coverage may be easily made on health insurance coverage between and among health insurers. The contract must require the clearinghouse to provide the pro forma rating upon request by any person.

Section 34. Section 39-71-704, MCA, is amended to read:

"39-71-704. Payment of medical, hospital, and related services -- fee schedules and hospital rates -- fee limitation. (1) In addition to the compensation provided under this chapter and as an additional benefit separate and apart from compensation benefits actually provided, the following must be furnished:

(a) After the happening of a compensable injury and subject to other provisions of this chapter, the insurer shall furnish reasonable primary medical services for conditions resulting from the injury for those periods as the nature of the injury or the process of recovery requires.

(b) The insurer shall furnish secondary medical services only upon a clear demonstration of cost-effectiveness of the services in returning the injured worker to actual employment.

(c) The insurer shall replace or repair prescription eyeglasses, prescription contact lenses, prescription hearing aids, and dentures that are damaged or lost as a result of an injury, as defined in 39-71-119, arising out of and in the course of employment.

(d) The insurer shall reimburse a worker for reasonable travel expenses incurred in travel to a medical provider for treatment of an injury only if the travel is incurred at the request of the insurer. Reimbursement must be at the rates allowed for reimbursement of travel by state employees.

(e) Except for the repair or replacement of a prosthesis furnished as a result of an industrial injury, the benefits provided for in this section terminate when they are not used for a period of 60 consecutive

months.

(f) Notwithstanding subsection (1)(a), the insurer may not be required to furnish, after the worker has achieved medical stability, palliative or maintenance care except:

(i) when provided to a worker who has been determined to be permanently totally disabled and for whom it is medically necessary to monitor administration of prescription medication to maintain the worker in a medically stationary condition; or

(ii) when necessary to monitor the status of a prosthetic device.

(g) If the worker's treating physician believes that palliative or maintenance care that would otherwise not be compensable under subsection (1)(f) is appropriate to enable the worker to continue current employment or that there is a clear probability of returning the worker to employment, the treating physician shall first request approval from the insurer for the treatment. If approval is not granted, the treating physician may request approval from the department for the treatment. The department shall appoint a panel of physicians, including at least one treating physician from the area of specialty in which the injured worker is being treated, pursuant to rules that the department may adopt, to review the proposed treatment and determine its appropriateness.

(h) Notwithstanding any other provisions of this chapter, the department, by rule and upon the advice of the professional licensing boards of practitioners affected by the rule, may exclude from compensability any medical treatment that the department finds to be unscientific, unproved, outmoded, or experimental.

(2) The department shall annually establish a schedule of fees for medical nonhospital services necessary for the treatment of injured workers. Charges submitted by providers must be the usual and customary charges for nonworkers' compensation patients. The department may require insurers to submit information to be used in establishing the schedule. The department shall establish utilization and treatment standards for all medical services provided for under this chapter in consultation with the standing medical advisory committees provided for in 39-71-1109.

(3) The department shall establish rates for hospital services necessary for the treatment of injured workers. ~~Beginning January 1, 1995, the~~ The rates may be based on per diem or diagnostic-related groups. The rates established by the department pursuant to this subsection may not be less than medicaid reimbursement rates. Approved rates must be in effect for a period of 12 months from the date of approval. The department may coordinate this ratesetting function with other public agencies that have similar

responsibilities. For services available in Montana, insurers are not required to pay facilities located outside Montana rates that are greater than those allowed for services delivered in Montana.

(4) The percentage increase in medical costs payable under this chapter may not exceed the annual percentage increase in the state's average weekly wage as defined in 39-71-116.

(5) Payment pursuant to reimbursement agreements between managed care organizations or preferred provider organizations and insurers is not bound by the provisions of this section.

(6) Disputes between an insurer and a medical service provider regarding the amount of a fee for medical services must be resolved by a hearing before the department upon written application of a party to the dispute.

(7) (a) After the initial visit, the worker is responsible for 20%, but not to exceed $10, of the cost of each subsequent visit to a medical service provider for treatment relating to a compensable injury or occupational disease, unless the visit is to a medical service provider in a managed care organization as requested by the insurer or is a visit to a preferred provider as requested by the insurer.

(b) After the initial visit, the worker is responsible for $25 of the cost of each subsequent visit to a hospital emergency department for treatment relating to a compensable injury or occupational disease.

(c) "Visit", as used in subsections (7)(a) and (7)(b), means each time the worker obtains services relating to a compensable injury or occupational disease from:

(i) a treating physician;

(ii) a physical therapist;

(iii) a psychologist; or

(iv) hospital outpatient services available in a nonhospital setting.

(d) A worker is not responsible for the cost of a subsequent visit pursuant to subsection (7)(a) if the visit is an examination requested by an insurer pursuant to 39-71-605.

(8) An insurer may not furnish a benefit required by this section through a physician or other health care provider who has not furnished the information required to be submitted to the information clearinghouse established pursuant to [section 28]."

NEW SECTION. **Section 35. Repealer.** Section 33-22-110, 33-22-1801, 33-22-1802, 33-22-1803, 33-22-1804, 33-22-1808, 33-22-1809, 33-22-1810, 33-22-1811, 33-22-1812, 33-22-1813, 33-22-1814, 33-22-1818, 33-22-1819, 33-22-1820, 33-22-1821, and 33-22-1822, MCA, are repealed.

NEW SECTION. **Section 36. Codification instruction.** (1) [Sections 2 through 6, 17 through 19, and 27 through 33] are intended to be codified as an integral part of Title 33, chapter 22, and the provisions of Title 33, chapter 22, apply to [sections 2 through 6, 17 through 19, and 27 through 33].

(2) [Sections 7 through 13 and section 23] are intended to be codified as an integral part of Title 15, and the provisions of Title 15 apply to [sections 7 through 13 and section 23].

(3) [Section 20] is intended to be codified as an integral part of Title 37, chapter 2, and the provisions of Title 37, chapter 2, apply to [section 20].

(4) [Section 21] is intended to be codified as an integral part of Title 50, chapter 5, and the provisions of Title 50, chapter 5, apply to [section 21].

(5) [Sections 23 through 26] are intended to be codified as an integral part of Title 53, and the provisions of Title 53 apply to [sections 23 through 26].

NEW SECTION. **Section 37. Saving clause.** [This act] does not affect rights and duties that matured, penalties that were incurred, or proceedings that were begun before [the effective date of this act].

NEW SECTION. **Section 38. Severability.** If a part of [this act] is invalid, all valid parts that are severable from the invalid part remain in effect. If a part of [this act] is invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications.

NEW SECTION. **Section 39. Effective dates.** (1) [Sections 13, 36 through 38, and this section] are effective on passage and approval.

(2) [Sections 1 through 12 and 14 through 35] are effective October 1, 1995.

-END-

STATE OF MONTANA - FISCAL NOTE

Revised Fiscal Note for SB0403, as introduced

DESCRIPTION OF PROPOSED LEGISLATION:
A bill relating to health care access and cost control; requiring health care insurers to offer a basic policy; prescribing minimum requirements for disability insurance; prohibiting the commissioner of insurance from prohibiting certain practices for setting premiums; providing for standardized disability insurance claim forms, electronic claims, and medical debit and credit cards; providing for medical savings accounts; providing for a tax exemption; amending the Montana Comprehensive Health Insurance Association plan; requiring health care insurers and providers to furnish certain data upon request by any person; providing for public support of insurance for the working poor; providing for a health care information clearinghouse; and repealing the Small Employer Health Insurance Availability Act.

ASSUMPTIONS:

State Auditor's Office:

1. Section 3: Existing staff will handle the filing of benefit plans. It is impossible to estimate whether contested hearings will be required for denial of plans. Hearings cost $2,500 each.
2. Section 6: Rules regarding electronic filing of forms will be revised. Ten pages of rules at $35/page and a rules hearing costing $2,500 will be required in FY96.
3. Section 19: There will be one complaint against an insurer and one against a producer each year. Fines will be levied as a result of half of the hearings. Implementation will not occur until FY97. Hearings costs will be $8,000; fines revenue $500.
4. Section 25: Five pages of rules will be adopted and updated annually to set the economic parameters of payment. Rules costs are $35/page, hearings $2,500.
5. Section 28: The Commissioner of Insurance will prepare the Request for Proposal (RFP) during FY96. Preparation will require 1.00 FTE grade 16 to work with the contractor and monitor compliance. The information necessary to set up the clearinghouse will require a contractor with the expertise to prepare the specifics of the RFP. Estimated cost is $200,000. It is difficult to estimate the cost of the clearinghouse contract, but the best estimate is $2,500,000 in FY97 for design and development and $750,000 per year for actual operations. The RFP will be put out and if the cost is more it will presented to the 1997 Legislature.
6. Section 29: Rules will be adopted specifying the format of information to be submitted to the clearinghouse. Ten pages of rules and a hearing will be required at a cost of $2,850.
7. Section 35 & 39: Repeal the existing small group insurance reform, which would be a reduction from the Executive Budget of 1.0 FTE and operating expenses.
8. Sections 15-17: Assumptions for MCHA costs and benefits:
   (a) The premium charged to Montana Comprehensive Health Insurance Association (MCHA) participants will decrease from the current level by 25%. The current premium is 200% of the average premium of the five insurers with the largest premium amount of individual major medical insurance in Montana. The bill would lower it by 25%, to 150% of the average premium amount;
   (b) The increase in benefits is estimated to cause claims to the MCHA plan to increase by an amount between 25% and 30%;

(continued)

Dave Lewis 2-21-95

DAVE LEWIS, BUDGET DIRECTOR DATE
Office of Budget and Program Planning

KEN MILLER, PRIMARY SPONSOR DATE

(c) The total 1994 premiums were $1,508,508. The program had an average of 278 participants throughout the year resulting in an average annual premium of $5,426 per participant;
(d) The expected assessment each year, based on comparable experience in other states with programs similar to the MCHA under this bill, is expected to be about 50% of the total premiums received in that year.
(e) It is estimated 52% of the MCHA assessment will be deducted dollar for dollar from the premium tax. (43% of the premium is collected by Blue Cross and Blue Shield of Montana, which is exempt from premium tax, and 5% is attributable to other companies that owe no premium tax in any given year.)
(f) The combined increase in benefits and the relative decrease in premiums will encourage more participation in the MCHA. Total enrollment will grow from 278 to 834.
(g) Assessments by the MCHA are deducted against premium tax due in the year following the assessment. The FY97 general fund revenue will be decreased by assessments levied during FY96 in the estimated amount of $1,076,636.

Department of Revenue (MDOR):

9. The income tax-related sections of the bill are effective October 1, 1995.
10. The bill applies to tax years beginning after December 31, 1995.
11. The Department of Social and Rehabilitation Services (SRS) would provide medical savings accounts for the working poor. It would also continue the state Medicaid program. The total of these two populations is assumed to be 90% of the state population. (Please see assumptions under SRS.)
12. If all households participated in the medical savings account program defined in the bill, the negative revenue impact for the individual income tax for tax year 1996 (FY97) would be $14.6 million for resident taxpayers (MDOR Income Tax Simulation Model). However, the only households which will not be subsidized by SRS for the medical savings accounts are those with adjusted gross income (AGI) of more than $100,000 (assumed to be 10% of Montanans). A straight percentage of the impact on the individual income tax would be estimated to be a loss of $1.46 million per year.
13. In order to implement the bill, the Department of Revenue would require 2.25 FTE (phased in over the first year) for increased error resolution, compliance, auditing workload and processing the new health insurance return; a line and a new form would need to be added to the individual income tax return with related programming and other data processing costs; and additional equipment would be necessary.

Department of Social and Rehabilitation Services (SRS):

14. The bill provides for SRS to contract with a vendor to administer funds which will be deposited into medical savings accounts for the working poor. The amount of each account will be the cost of purchasing a basic benefit policy with an annual deductible of $1,000, minus an amount of liability recommended by the insurance commission, and plus the deductible for the plan. The contractor will pay the premiums for insurance out of the account and administer the remaining funds (one-half of which return to the general fund at the end of the plan year. The other half of the balance is retained by the recipient in the account.) (Please see Technical Notes.)
15. SRS will continue to administer the state Medicaid program.
16. Persons now eligible for the Medicaid program most likely will not participate in a medical savings account because the minimum insurance policy required in SB403 is less comprehensive than what they are currently eligible for under the Medicaid program. Therefore, for the purposes of this fiscal note, no savings are assumed from persons leaving the Medicaid program.
17. SRS will pick up the cost of medical savings accounts for the working poor (who are not Medicaid eligible). Assuming that Montana has a population of 847,000, and 90%

(continued)

would fall in the definition of working poor, then 762,000 Montanans would qualify as working poor under this bill. Of those, roughly 58,000 are Medicaid recipients. Therefore, about 704,000 Montanans would receive subsidies for the medical savings accounts. With an average family size of four people, and an average monthly premium per family of $250 plus an annual deductible of $1,000, the total subsidies per family would be $4,000 annually. For the 176,000 families, the annual total would be $704,000,000 general fund.

18. The administrative contract costs to SRS for the medical savings accounts are estimated to be $2.15 per contract per month, based on the state employees flexible benefits plan administrative costs. For 176,000 contracts, the annual administrative cost would be $4,540,800, entirely funded by general fund.
19. Assume that the contract for administering the medical savings account is effective October 1, 1995, the effective date of the applicable sections.
20. There will be 1.00 FTE grade 15 assigned to manage this contract.

FISCAL IMPACT:

Expenditures:

House Bill No. 2	FY96 Difference	FY97 Difference
FTE	2.13	3.25
Personal Services	52,473	76,463
Operating	3,655,935	7,769,288
Equipment	18,428	0
Benefits	528,000,000	704,000,000
Total Expenditures	531,726,836	711,845,751
Funding:		
General Fund (01)	531,756,836	711,875,751
State Special (02)	(30,000)	(30,000)
Total Funds	531,726,836	711,845,751
Revenue:		
General Fund (01)	0	(1,460,000)
Total Net Impact on General Fund Balance:		
General Fund (Cost) (01)	(531,756,836)	(713,335,751)

LONG-RANGE EFFECTS OF PROPOSED LEGISLATION:
Future increases or decreases in participation in the MCHA will impact general fund revenues accordingly.
Health insurance premiums and other health care costs may increase over time. Because these increases are likely and assuming increased participation in medical savings accounts, it is possible that the negative revenue impact of medical savings accounts will increase in the long term.

TECHNICAL NOTE:
Section 10 (6) and Section 10 (7) of the bill may be in conflict. Section 10 (6) specifies that withdrawals for certain purposes will not be taxed, while Section 10 (7) refers back to section 10 (6) and specifies that these withdrawals are taxable.

Section 6 requires the commissioner of insurance to adopt rules to use the HCFA 1500 as a standard billing form for all health care providers. Some providers, such as hospitals, dentists and pharmacies, use different HCFA forms and are unable to use the HCFA 1500 claim form due to the nature of the information required for these providers to submit a claim.

APPROVED BY COM ON PUBLIC
HEALTH, WELFARE & SAFETY

SENATE BILL NO. 403

INTRODUCED BY Miller ORR

A BILL FOR AN ACT ENTITLED: "AN ACT RELATING TO HEALTH CARE ACCESS AND COST CONTROL; REQUIRING HEALTH CARE INSURERS TO OFFER A BASIC POLICY; PRESCRIBING MINIMUM REQUIREMENTS FOR DISABILITY INSURANCE; PROHIBITING THE COMMISSIONER OF INSURANCE FROM PROHIBITING CERTAIN PRACTICES FOR SETTING PREMIUMS; PROVIDING FOR STANDARDIZED DISABILITY INSURANCE CLAIMS FORMS, ELECTRONIC CLAIMS, AND MEDICAL DEBIT AND CREDIT CARDS; PROVIDING FOR MEDICAL SAVINGS ACCOUNTS; PROVIDING FOR A TAX EXEMPTION; AMENDING THE MONTANA COMPREHENSIVE HEALTH INSURANCE ASSOCIATION PLAN; REQUIRING HEALTH CARE INSURERS AND PROVIDERS TO FURNISH CERTAIN DATA UPON REQUEST BY ANY PERSON; PROVIDING DEFINITIONS; PROVIDING PENALTIES; REQUIRING A HEALTH INSURANCE RETURN; PROVIDING FOR PUBLIC SUPPORT OF INSURANCE FOR THE WORKING POOR; PROVIDING FOR A HEALTH CARE INFORMATION CLEARINGHOUSE; REPEALING THE SMALL EMPLOYER HEALTH INSURANCE AVAILABILITY ACT; AMENDING SECTIONS 15-30-111, 33-22-101, 33-22-1512, 33-22-1521, AND 39-71-704, MCA; REPEALING SECTIONS 33-22-110, 33-22-1801, 33-22-1802, 33-22-1803, 33-22-1804, 33-22-1808, 33-22-1809, 33-22-1810, 33-22-1811, 33-22-1812, 33-22-1813, 33-22-1814, 33-22-1818, 33-22-1819, 33-22-1820, 33-22-1821, AND 33-22-1822, MCA; AND PROVIDING EFFECTIVE DATES."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

THERE ARE NO CHANGES IN THIS BILL AND IT WILL NOT BE REPRINTED. PLEASE REFER TO INTRODUCED COPY (WHITE) FOR COMPLETE TEXT.